

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11306

CERTIFICATE OF DEATH

Reg. Dist. No.....

11324

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Indian Head (If rural give location)
Charles Indian Head	30 yrs	Md Indian Head	Charles 19 Indian Head Ave
HOSPITAL OR INSTITUTION OR STREET ADDRESS	19 Indian Head Ave		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) William Chiles Abel		(Month) Oct. 27 (Year) 1959	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 5, 1904
9. AGE last birthday 55 yrs.	10. KIND OF BUSINESS OR INDUSTRY Auto Sales		11. BIRTHPLACE (State or foreign country) Indian Head, Md.
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Dr. K. Custis Abel	
14. MOTHER'S MAIDEN NAME Ora Ella Mitchell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 220-32-5842		17. INFORMANT & ADDRESS Mrs Wm. C. Abel, 19 Indian Head Ave, Indian Head, Md.	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) Coronary Thrombosis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Arteriosclerotic Heart Disease GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....P.M., from the causes and on the date stated above. SIGNATURE Frank G. Duran M.D.			
ADDRESS (Street, city, town, state) Indian Head 824 DATE SIGNED 10-27-59			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-30-59	NAME OF CEMETERY OR CREMATORIAL Park Hill
24. REC'D BY REGISTRAR NOV 4 '59 DATE		REGISTRAR'S SIGNATURE C. M. Miles	LOCATION (City, town, or county) Danbury, Md. (State)
25. FUNERAL DIRECTOR'S SIGNATURE Arehat Funeral Home, Inc. Lat. 50th, Md.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11307

Reg. Dist. No.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or removal.

V.S. A1SME(5)
 5M 9/55

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	c. LENGTH OF STAY IN lb <i>none</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	d. STREET ADDRESS <i>/</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>none</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JOHN HARRISON COOMBS</i>	First <i>HARRISON</i>	Middle <i></i>	Last <i>COOMBS</i>
4. DATE OF DEATH <i>OCTOBER 1 1959</i>	Month <i>OCTOBER</i>	Day <i>1</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 9, 1915</i>
9. AGE (In years last birthday) <i>44</i> yrs.	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>restaurant worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>restaurant</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Joseph Coombs</i>	14. MOTHER'S MAIDEN NAME <i>Matilda Lee</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Julia Johnson, La Plata Md</i>	Address <i></i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Bilateral Pneumonia</i> <i>490X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Addiction to alcohol</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>none</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>		
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> 19	20d. INJURY OCCURRED While <i>Not while</i> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <i>La Plata, Charles, Md.</i>
21. I certify that took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>V.B. Dettor</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>10-3-59</i>
EXAMINER'S NAME (Type) <i>V.B. DETTOR M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-5-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Sacred Heart Cem</i>	22d. LOCATION (City, town, or county) (State) <i>La Plata Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home, Waldorf Md</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>OCT 6 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur & Times</i>

23. ~~most~~ ^{most} varieties. about ^{the} same
~~in~~ ⁱⁿ most cases ^{various} types of
herbaceous annuals.

all used stock except

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11326

CERTIFICATE OF DEATH

Reg. Dist. No.

11308

1. PLACE OF DEATH a. COUNTY CHARLES		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WALDORF		c. LENGTH OF STAY IN 1b 8 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WALDORF			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 1 Box 58		d. STREET ADDRESS RT 1 Box 58		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LLOYD	First GEORGE	Middle DIXON JR.	Last Oct. 22 1959	4. DATE OF DEATH Oct. 22 1959	Month Oct.	Day 22	Year 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH FEB. 13 1941	9. AGE (In years lost birthday) 18 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) DISTRICT OF COLUMBIA USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LLOYD GEORGE DIXON		14. MOTHER'S MAIDEN NAME DOROTHY MAY SMITH					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT DOROTHY H. DIXON - MOTHER		Address RT 1 Box 58 WALDORF MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 355X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
TERMINAL BRONCHOPNEUMONIA INTERVAL BETWEEN ONSET AND DEATH 20 days							
SPINO-CEREBELLAR ATAXIA 4 YRS.							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							
UREMIA - 2 mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour o. m. NOV 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) HOME		20f. (City or town) (County) (State) NOVA	
21. I certify that I attended the deceased from OCT 22 1959 to PRESENT , that I last saw the deceased alive on OCT 22 1959 , and that death occurred at 11:58 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) ARTHUR SHAVER JR. M.D. BRANCH AVE., CLINTON, MD. 10/22/59							
DATE SIGNED 10/22/59							
ACTUAL SIGNATURE Arthur Shaver Jr. M.D.		PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. M.D. BRANCH AVE., CLINTON, MD. 10/22/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct 26-59		22b. DATE THEREOF Oct 26-59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Summers Bros.		ADDRESS 1661-9d Stage Rd & E		24a. REC'D BY REGISTRAR Oct 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shown detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11309

Reg. Dist. No.

11327

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Arehart Funeral Home, Inc.		d. STREET ADDRESS 414 Westgrove Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First GORDON	Middle O.	Last JOHNSON	4. DATE OF DEATH	Month October	Day 18,	Year 1959
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> August 6, 1909	9. AGE (In years at birthday) 50 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Manager, Supt.	10b. KIND OF BUSINESS OR INDUSTRY Gosnell & Inc.	11. BIRTHPLACE (State or foreign country) North Dakota	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Edward Johnson	14. MOTHER'S MAIDEN NAME Lynn Paulson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WWII 578-40-2347	17. INFORMANT J.E. Johnson, 14E. Reed Ave, Alexandria, Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning		
850 x DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO		
(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off boat		20c. TIME OF INJURY Month, Day, Year Hour a. m. XOBOCK 10/18/1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River	20f. (City or town) LaPlata	(County) Charles	(State) Md.
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21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
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ACTUAL SIGNATURE <i>R.S. Fisher</i>	M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED 10/19/59
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-21-1959	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery	22d. LOCATION (City, town, or county) Fort Myer, Virginia.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Edwards</i>	ADDRESS # 333	REC'D BY REGISTRAR Oct 21 1959	24b. REGISTRAR'S SIGNATURE <i>A. J. Edwards</i>	
DATE OCT 21 1959				

ST. FRANCIS-HIGH SCHOOL MEMPHIS STATE CHARTER
HTAED-RO STAFFED ELEMENTARY JAZZ

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11328

CERTIFICATE OF DEATH

Reg. Dist. No.

11311

1. PLACE OF DEATH o. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Plate	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial		d. STREET ADDRESS 121 Kenwood Place	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First John	Middle Carroll	Last McWilliams		
4. DATE OF DEATH Month Oct	Day 22	Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 6, 1890	9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Propellant Plant		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emmanuel McWilliams		14. MOTHER'S MAIDEN NAME Paravall E.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. John C. McWilliams, Indian Head, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 6 hrs.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Artusia Sclerotic Heart Disease (c)				10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? None YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 5 Indian Head Ave	(County) (State)
21. I certify that I attended the deceased from _____, 1949, to Oct 22, 1959, that I last saw the deceased alive on Oct 22, 1959, and that death occurred at 12:54 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5 Indian Head Ave DATE SIGNED 10/23/59 ACTUAL SIGNATURE Frank G. Susan M.D.					
PHYSICIAN'S NAME (Type) Frank A. Susan M.D.		I Indian Head, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-24-59	22c. NAME OF CEMETERY OR CREMATORIAL St Marys	22d. LOCATION (City, town, or county) Piscataway, N.J. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE The Smith Funeral Home, Waldorf, Md.		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
			DATE OCT 26 '59	Cathleen S. Trahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11312

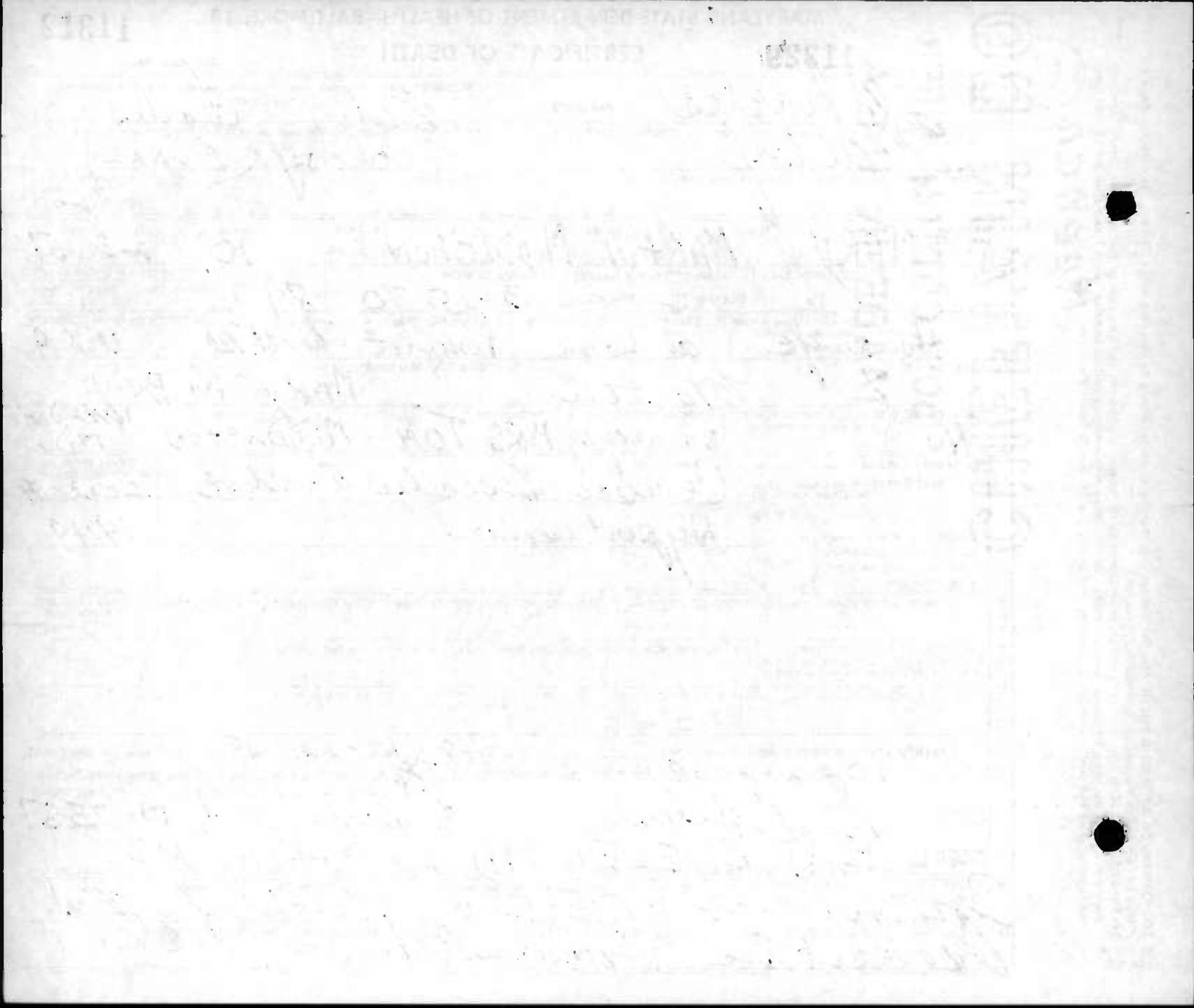
11329

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>	c. LENGTH OF STAY IN 1b <i>1 week</i>	b. COUNTY <i>Charles</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf RURAL</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>	d. STREET ADDRESS <i>None</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>MARY</i>		First	Middle			
		<i>MARTIN</i>	Last			
		4. DATE OF DEATH Month <i>10</i> Day <i>23</i> Year <i>1959</i>				
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-15-70</i> 9. AGE (In years (month/day) yrs.) <i>89</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Somerset Chancery U.S.A.</i>			
13. FATHER'S NAME <i>John Martin</i>		14. MOTHER'S MAIDEN NAME <i>MARY Robey</i>	12. CITIZEN OF WHAT COUNTRY? <i>Waldorf MD</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NOT KNOWN</i>	INFORMANT <i>MRS TOM MIDDLETON</i>			
			Address <i>Waldorf MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-Vascular Accident</i>						
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Hypertension</i>		DUE TO (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <i>10-22-59</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>						
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>La Plata</i>	20f. (City or town) <i>La Plata</i>	(County) <i>MD</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, P.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>La Plata, MD</i>	DATE SIGNED <i>10-25-59</i>	
ACTUAL SIGNATURE <i>E. J. Edelean</i>		PHYSICIAN'S NAME (Type) <i>E. J. EDELEAN M.D.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 10-26-59</i>		22b. DATE THEREOF <i>10-26-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St Peters</i>	22d. LOCATION (City, town, or county) <i>Waldorf</i>	(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Lee. Ochsler</i>		ADDRESS <i>Robert Lee. Ochsler</i>	24a. REC'D BY REGISTRAR DATE <i>OCT 28 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11330

CERTIFICATE OF DEATH

11313

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Faulkner			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians' Memorial Hosp.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Clyde	Middle Allen	Last Putnam	4. DATE OF DEATH Oct.	Month 28	Day 19	Year 59
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-19-1892	9. AGE (In years at birthday) 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Bridgework		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Edward Putnam		14. MOTHER'S MAIDEN NAME Margaret Susan Brown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WII		17. INFORMANT Mrs. Clyde A. Putnam, Faulkner, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Generalized Arterio Sclerosis				1957			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 1953, to Oct. 28, 1959, that I last saw the deceased alive on Oct. 28, 1959, and that death occurred at 2 PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. J. Edelen</i>		M.D.		ADDRESS (Street, city or town, state) 10-2959 DATE SIGNED La Plata, Maryland			
PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-31-59		22c. NAME OF CEMETERY OR CREMATORIUM Dentsville Methodist		22d. LOCATION (City, town, or county) (State) Dentsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 „БРОНТОДИСКИИ И ТРЕНАЖЕРЫ ДЛЯ ПОДДЕРЖАНИЯ ФУНКЦИИ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11314

11331

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i>		c. LENGTH OF STAY IN 1b <i>26 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1201 E. Raymond St.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <i>1201 E. Raymond St</i>	
3. NAME OF DECEASED (Type or print)	First <i>James</i>	Middle <i>Daniel</i>	Last <i>Speake</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 28, 1905</i>
9. AGE (In years last birthday) <i>64</i> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter (Ret.)</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Newspaper Plant</i>	11. BIRTHPLACE (State or foreign country) <i>Chicomuken, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	13. FATHER'S NAME <i>James Lee Speake</i>		
14. MOTHER'S MAIDEN NAME <i>Beulah Groues</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>213-38-1831</i>		17. INFORMANT <i>John J. Speake, 1201 E. Raymond St., Indian Head, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		Address <i>1201 E. Raymond St., Indian Head, Md.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>immed.</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white At work <input type="checkbox"/> At work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank A. Susan</i>		ADDRESS (Street, city or town, state) <i>5 Indian Head Ave</i>	
PHYSICIAN'S NAME (Type) <i>Frank A. Susan M.D.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/28/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Chicomuken Cemetery</i>		22d. LOCATION (City, town, or county) <i>Chicomuken</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harriet Turner/Horne</i>		24a. REC'D BY REGISTRAR DATE <i>Oct 30 '59</i>	
ADDRESS <i>Waldorf Rd</i>		24b. REGISTRAR'S SIGNATURE <i>Carrie S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar or to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

DEATH CERTIFICATE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 FilmG250 10-27-59 et

11315

11332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ta Plata</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION — <i>Physicians Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JAMES H THOMPSON</i>		First <i>JAMES</i>	Middle <i>H</i>
		Last <i>THOMPSON</i>	4. DATE OF DEATH Month <i>OCTOBER</i> Day <i>13</i> Year <i>1959</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>2-2-1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Hicks</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Maurice J. Butler - 102-N. St. SW.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteria</i> <i>610X</i>		2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Benign Prostatic Obstruction</i> (c) <i>Chronic arteriosclerotic Renal Disease</i>		4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <i>No injury</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>No injury</i>
20f. (City or town) <i>No injury</i>		(County) <i>No injury</i> (State) <i>No injury</i>	
21. I certify that I attended the deceased from <i>10-2</i> , 19 <i>59</i> , to <i>10-13</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>10-13</i> , 19 <i>59</i> , and that death occurred at <i>11:20 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>V.B. Dettor</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>10-14-59</i>	
PHYSICIAN'S NAME (Type) <i>V.B. DETTOR M.D.</i>		22d. LOCATION (City, town, or county) <i>Charler County, Md.</i> (State) <i>Charler County, Md.</i>	
22e. DATE THEREOF <i>10-19-59</i>		22f. NAME OF CEMETERY OR CREMATORY <i>Montgomery Bros.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Montgomery Bros.</i>		24a. REC'D BY REGISTRAR and DATE <i>OCT 21 '59</i>	
VS A15 (4) 15M 9/55		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEXICAN STATE GOVERNMENT OF HESSEN - VALDERRAMA

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11316

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Charles -</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Alton</i>		c. LENGTH OF STAY IN 1b <i>1 week.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Roy (N.M.N.)</i>		First	Middle
4. DATE OF DEATH <i>Tyler</i>		Last	Month
5. SEX <i>M</i>		Year	Day
6. COLOR OR RACE <i>White</i>		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>JULY 20, 1910</i>		9. AGE (in years last birthday) <i>49 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saw Mill Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Saw Mill</i>	
11. BIRTHPLACE (State or foreign country) <i>Columbia Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Allie G. Tyler.</i>		14. MOTHER'S MAIDEN NAME <i>Lillian Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>Yes.</i>	
17. INFORMANT <i>Mr. Jack C. Tyler - Columbia</i>		Address <i>Coronary Occlusion</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>10-15-59</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Logging when he collapsed</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Natural causes</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E.J. Edelen</i>		DATE SIGNED <i>10-12-59</i>	
EXAMINER'S NAME (Type) <i>E.J. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-18-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Gleasant Grove</i>		22d. LOCATION (City, town, or county) <i>Columbia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thomasson Funeral Home, Lousia</i>		24a. REC'D BY REGISTRAR DATE OCT 21 '59	
ADDRESS <i>Grehart Funeral Home, Sates</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
11334 Charles		MARYLAND Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Mt Victoria	Life	Mt Victoria	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
James		Chester	Washington
4. DATE OF DEATH	Month	Day	Year
Oct.	6		1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
MALE	NEGRO		3-13-55
9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
4 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY?			
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Chester Edward Washington		Nellie Ann Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT	
		None Louise Brown, Mt Victoria, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1h. 15m.	
881.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Gasoline Poisoning	
(b) DUE TO (c)		Ingestion of Gasoline	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
none			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drank from a can -	
20c. TIME OF INJURY Month, Day, Year 5:30 p.m. 10-6 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Mt VICTORIA, CHARLES, MD. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE V. B. Detter		DATE SIGNED 10-6-59	
EXAMINER'S NAME (Type) V. B. DETTER MD.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-59	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) (State) Holy Ghost	
23. FUNERAL DIRECTOR'S SIGNATURE The Lund Funeral Home, Waldorf, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR DATE OCT 9 '59	
		24b. REGISTRAR'S SIGNATURE Claims & Trans.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1931
ST. LOUIS AREA FEDERAL RESERVE BANK
FEDERAL EXAMINING & COUNSELING DEPARTMENT

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80330	80331	80332	80333	80334	80335	80336	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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11335 Item 2 Film G250 10-19-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE DIST. OF COLUMBIA COUNTY	
LA PLATA		None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				f. STREET ADDRESS U.S. SOLDIERS HOME	
PHYSICIAN'S MEMORIAL HOSP.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
WILLIAM J.				WELCH	OCTOBER 12 1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 78 yrs.
MALE		WHITE		8/9/1881	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
U.S. ARMY		MILITARY		PORTLAND, ME	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES		16. SOCIAL SECURITY NO. PI + WWI 538-16-4266		17. INFORMANT Records Address	
				U.S. Soldiers' Home, WASH 25, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: Acute Myocardial Infarction 5 min.					
IMMEDIATE CAUSE (a) DUE TO					
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO					
Arteriosclerotic Heart Disease years (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
none known					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MEDICAL CERTIFICATION					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
none		Collapsed from chair in restaurant			
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	
Hour 12:20 p.m. 10-12 1959		White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20f. (City or town) (County) (State)	
		Restaurant		WALDORF, CHARLES, MD.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Nutrol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE		DATE SIGNED			
V.B. DETTOR		10-12-59			
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
10/14/59		U.S. SOLDIERS HOME NATL.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Stanley Jones, Soldiers Home				OCT 14 '59	
VS. A15ME(5) 5M 9/55		24b. REGISTRAR'S SIGNATURE			

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